

FEB 25 1937

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1319

1. PLACE OF DEATH

County Jackson
 Township Ray
 City Kansas City (No. North East Hospital)

Registration District No. 299Primary Registration District No. 002File No. 130

Registered No. _____

St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 3730

(Usual place of abode)

Bellman St.,Ward. 1

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

Feb 26 - 1911

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

251012

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Salina Kansas

FATHER

13. NAME

A. J. Lewis

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Fresno Kansas

MOTHER

15. MAIDEN NAME

Virginia Lewis

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Feb

17. INFORMANT (ADDRESS)

Mr. Hiller

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

CalvaryJan 9 - 1937

19. UNDERTAKER (ADDRESS)

W. H. Schaefer

20. FILED

1-8

1937

Wm. Brown

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

Jan 7 - 1937

22. I HEREBY CERTIFY, that I attended deceased from

Nov 30, 1937, to Jan 6, 1937I last saw him alive on Jan 6, 1937. Death is saidto have occurred on the date stated above, at 3:30 p. m.

The principal cause of death and related causes of importance were as follows:

Acute cardiac dilatation
Acute uraemic poison

Date of onset

Other contributory causes of importance:

Multiple bowel obstructions

Name of operation

LaparotomyDate of 1/8/37What test confirmed diagnosis? Physiographic. Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W. H. Schaefer(Address) 1748 SchaeferCity

AT 11:00 AM

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City..... (No. *North East Hospital*)..... St. Ward)

File No. *110.*
Registered No.
St. Ward)

2. FULL NAME

Edna Hiller

(a) Residence, No. *3730 Baltimore* St., Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as splanner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED *1/8 37 M. M. Crowe* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *1-7* 19*37*

22. I HEREBY CERTIFY, That I attended deceased from 19....., to..... 19.....

I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at..... m.
The principal cause of death and related causes of importance were as follows:

*Acute Cardiac Dilatation
Acute Hemiparesis
secondary to Chr. nephritis*

Other contributory causes of importance:
*Multiple Bowel Obstruction
do to salpingitis (post-trauma) peritonitis
general. 6 months later lap was done by*
Name of operation *laparotomy* Date of *1-3-37*
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) *F. A. De Melly* M. D.
(Address) *2748 Chaffin St. Ely*

S-1319

